

Progress in Medicine: Compensation and medical negligence in India: Does the system need a quick fix or an overhaul?

Meghana S. Chandra, Suresh Bada Math¹

Graduate Student, Irving B Harris School of Public Policy, University of Chicago, Chicago, Illinois, USA, ¹Department of Psychiatry, National Institute of Mental Health and Neuro Sciences, Bengaluru, Karnataka, India

Abstract

In a recent judgment on medical negligence, the Supreme Court awarded compensation amounting to Rs. 11 crore to a victim, which was to be paid by the doctors and the private hospital deemed responsible for the wrongful death of a patient. This landmark decision was by far the largest compensation award in the history of Indian medical negligence litigation. Hence, the process of calculating compensation for medical negligence has received great attention and debate, largely due to the impact that it is going to have on the practice of medicine within the country, in the near future. However, the method of calculation of compensation is unpredictable as it varies hugely across different cases, courts and tribunals resulting, in a loss of faith in the system, protracted litigation, and frequent appeals. With over 80% of India's healthcare being provided by the private sector, predictability and uniformity in the regulation of compensation in medical negligence would benefit the victims and the doctors concerned. A basic knowledge of how medical negligence compensation is calculated and adjudicated in the judicial courts of India will aid a doctor in planning his/her professional indemnity insurance, as well as in practicing his/her profession without undue worry about facing litigation for alleged medical negligence. This article addresses the merits and demerits of large compensation awards, and also discusses whether the system is broken, needs a quick fix, or a massive overhaul.

Key Words

Civil liability, compensation, consumer court, medical malpractice, medical negligence

For correspondence:

Dr. Suresh Bada Math, Department of Psychiatry, National Institute of Mental Health and Neuro Sciences, Bengaluru - 560 029, Karnataka, India.
E-mail: sureshbm@gmail.com

Ann Indian Acad Neurol 2016;19:S21-27

Introduction

The Supreme Court of India relaxed the norms for doctors with regard to criminal liability for medical negligence by adding the requirement of "gross" medical negligence.^[1-3] However, they have recognized the culpability of doctors through civil liability by awarding large compensation awards. The recent judgment awarding compensation of Rs. 11 crore was by far the biggest payout in the history of Indian medical negligence litigation.^[4]

The advent of high compensation awards for medical negligence claims in India has resulted in apprehensive

conjecture regarding the impact that such awards may have on the manner in which doctors practice medicine within India and how this consequently translates into rising costs for patients. While some predict a consequent rise in frivolous litigation, others posit the argument that the health sector in India needs to be regulated more stringently^[5] and that the fear of large compensation awards will ensure that doctors are not negligent.^[6] In light of the recent judgments offering large compensation amounts,^[4,7,8] it is pertinent to examine if

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.

For reprints contact: reprints@medknow.com

How to cite this article: Chandra MS, Math SB. Progress in Medicine: Compensation and medical negligence in India: Does the system need a quick fix or an overhaul?. *Ann Indian Acad Neurol* 2016;19:S21-7.

Received: 16-08-16, **Revised:** 01-09-16, **Accepted:** 04-09-16

Access this article online

Quick Response Code:



Website:

www.annalsofian.org

DOI:

10.4103/0972-2327.192887

this signals the beginning of increasing medical negligence litigation and the practice of defensive medicine,^[9] and if there is a consequent need to modify the manner in which medical negligence is currently addressed in India.

India's health-care system has to account for and regulate private (individual and corporate), public, and not-for-profit hospitals within its framework. In addition, the Indian government is bound to ensure universal access to healthcare^[10] through the public health sector. It is, therefore, incumbent upon the judiciary to balance the interests and rights of all concerned parties.

The decision to take legal action against a practitioner may be determined not only by the original injury but also by insensitive handling and poor communication after the original incident.^[11] Thus, a patient who alleges medical negligence can resort to any of the following legal remedies: (a) Complaining to the State Medical Council, (b) filing a case before a consumer court, (c) filing a case before a civil court, and (d) filing a criminal complaint citing gross negligence.^[12,13]

Compensation for medical negligence, however, can be provided only by a consumer court or civil court; therefore, our discussion in this article shall be restricted to the same. This article attempts to cull out the principles used to provide compensation in medical negligence claims in India; it also addresses arguments in favor of, and against, providing large compensation amounts to victims of medical negligence, and lastly it discusses various suggestions to address the present dilemma in relation to medical negligence in the framework of India's legal system, given the various constraints posed by the infrastructure within the health and legal sectors in India.

Calculating Compensation

The basis of computing compensation under common law lies in the principle of "restitutio in integrum," which, when translated, refers to ensuring that the person seeking damages due to a wrong committed to him/her is in the position that he/she would have been had the wrong not been committed.^[14] This implies that the victim needs to be compensated for financial loss caused by the doctor's/hospital's negligence, future medical expenses, and any pain and suffering endured by the victim.

India, unlike the USA, does not have a jury system that determines culpability or quantum of compensation. In India, the judge in the consumer court, or the civil court, has complete discretion over the compensation amount and hence is bound to consider the impact of the judgment because he/she sets a precedent even in the manner and quantum of damages awarded. Readers are requested to refer the scholarly research article by Agarwal^[15] and following judicial decisions on the calculation for compensation for the loss of consortium in *Dr. Balram Prasad vs. Kunal Saha*^[4] and *Rajesh and Ors. Rajvir Singh V and Ors.*^[16] Inconsistency in awarding compensation in medical negligence cases is a problem that currently plagues the Indian health sector. Every case is required to be considered independently^[17]

because it would be inappropriate to not give the facts of every situation due importance. However, this increases the unpredictability and the scope of discretion provided to the judge in such situations.

As the Supreme Court noted:^[18]

"The lack of uniformity and consistency in awarding compensation has been a matter of grave concern... If different tribunals calculate compensation differently on the same facts, the claimant, the litigant, the common man will be confused, perplexed, and bewildered. If there is significant divergence among tribunals in determining the quantum of compensation on similar facts, it will lead to dissatisfaction and distrust in the system."

The defendants in most medical negligence cases assert that the method of determining compensation ought to be the "multiplier method."^[4] The principal argument in favor of using such a method is uniformity and predictability. Doctors and hospitals will not be compelled to pay large sums of money to compensate for negligence.

The multiplier method was created to facilitate awarding compensation in relation to motor vehicle accidents to calculate "no-fault" liability. Therefore, it accounts for the loss of income of the victim only. This sum is calculated by taking into account the "multiplicand," that is, the victim's salary minus the amount he spends on himself, and the "multiplier," that is, the total number of years that the victim would have earned his salary. The multiplier is calculated by taking into account, average life expectancy, the victim's age, the number of years that the victim will be unemployed, and any other factors concerning the victim's health. The usual formula utilized in calculating compensation is $((70 - \text{age}) \times \text{annual income} + 30\% \text{ for inflation} - 1/3 \text{ for expenses})$. Defendants assert that this is the figure that will adequately calculate the loss incurred, and therefore it should be utilized in cases of medical negligence. However, compensation that is solely based on the income of the victim would imply that medical negligence causing death or injury to a wealthy individual is worth more than medical negligence that impacts an unemployed individual or homemaker or a child or senior citizen. The Supreme Court has, therefore, refused to restrict compensation to the multiplier method in the case of medical negligence.^[4,7] Further, the Supreme Court has added other dimensions to the calculation of compensation such as the medical costs incurred by the victim during the litigation, cost of future medical expenses, compensation toward mental agony and physical pain, and compensation toward loss of consortium and cost of litigation.

However, the dilemma that judges face while awarding compensation in medical negligence cases is largely due to the following: (a) The law is required to protect a patient's rights and (b) the law also needs to provide due autonomy to a profession that by all definitions are an inexact science.

The Supreme Court has devised various grounds under which it awards compensation in medical negligence cases as indicated in Table 1.

Table 1: The various factors and the reasoning behind the compensation awarded in various judgments

Grounds for awarding compensation	Reasoning used
Loss of income	Loss of income for the deceased/injured is calculated based on previous income, and future prospects for increase in income on the basis of status, qualification, and standard of living of the victim. The loss of income is accounted for by calculating the monthly salary on the basis of qualifications and expert evidence, subtracting 30% of the same to account for personal expenses. ^[19] This sum is the multiplicand, and the multiplier is the life expectancy minus the age of the victim In the event, the person in question is a parent who stays at home, compensation can be calculated on the basis of loss of gratuitous services* ^[20]
Medical costs till date of judgment	The medical costs incurred by the victim and his/her family are calculated on the basis of evidentiary proof (i.e., bills provided) and circumstances. In Kunal Saha's case, the travel and cost of stay were also provided for because it was directly linked to the negligent behavior of the doctors and hospital in question
Future medical costs	Future medical costs arising due to the negligence of the doctors/hospitals can include the need for a driver, nursing care, physiotherapy, etc., The claimant is required to prove the need for the same is the consequence of medical negligence ^[7]
Pain and suffering	The calculation for pain and suffering accounts for the age of the victim, and the severity of the injuries, consequent suffering endured, and awareness of suffering. Due regard is given to precedent, preventing large awards ^[4] Emotional distress of relatives has been deemed to be indirectly linked to the medical negligence, and therefore no compensation can be awarded in relation to the same ^[4]
Cost of litigation	Travel to the venue of litigation and the cost of lawyers employed throughout the course of litigation is considered to arrive at appropriate figure for the cost of litigation ^[4]
Inflation and interest	The court is not restricted to the amount claimed by the claimant, inflation needs to be considered. ^[21] The court also accounts for the interest on the amount claimed
Punitive compensation	Courts have generally not awarded compensation solely on the grounds of punitive compensation in India. In a recent judgment, the National Consumer Dispute Redressal Commission imposed rupees ten lakh solely as punitive compensation ^[22]
Loss of consortium	Loss of consortium refers to the loss of companionship, care, protection of a spouse due to the medical negligence ^[16]

*It should be noted that this was a motor vehicle accident litigation case and consequently in accordance with the second schedule of the Motor Vehicle Act, 1988, the notional income was calculated as 1/3rd of the spouse's monthly income

Argument in Favor of Large Compensation Awards

A patient who has suffered due to medical negligence may choose how they would like the problem addressed. If it is accountability they seek, they may approach the State Medical Council,^[23] and if it is compensation that they desire, they go to the civil court or consumer court. However, the compensation is considered an ideal remedy for medical negligence because it acts as insurance to the victim, retribution toward negligent doctors and hospitals, and as a deterrent to other doctors/hospitals.

Coverage for victims

Compensation as a legal remedy provides victims of medical negligence with the resources they require to cover medical costs, future medical expenses, loss of income, cost of litigation, etc., provided they prove that the doctor or hospital in question was negligent. This mechanism attempts to ensure victims are financially provided for allowing them to bear the consequences of medical negligence, be it injury or wrongful death.

Retribution

The compensation amount imposed by the court will be paid for, by the hospital or the doctors, based on the determination of liability and the judge's directions/discretion regarding the same. This ensures that the parties guilty of negligence are made to pay for their actions.

Deterrence

Large compensation amounts penalize negligent doctors heavily; therefore, it is predicted that doctors will be more

careful because one case could result in grave losses. Large compensation, especially when it includes punitive damages, will result in incentivizing allocation of resources toward safety. Furthermore, it acts as an expression of the community's indignation toward an abhorrent crime and therefore imposes a civil sanction against it. In fact, large compensation could act as a civil enforcement mechanism because it rewards the plaintiff for initiating litigation, and thereby supplements the criminal justice system.^[24]

Counter-argument against Large Compensation Awards

Large compensation awards also have their fair share of detractors, who point to the increase in defensive medicine, professional liability premiums, and treatment costs as symptoms of a dysfunctional system created to reward the litigious and punish the professionals.

Inequity

The manner in which medical negligence compensation is calculated depends not just on the injury sustained or the death caused but is also contingent on the victim's income and standard of living. This system, therefore, perpetuates inequity by providing greater compensation to the rich, for the same injury or wrongful death claim, which prompts the question, how does one assess how much a life is worth?

The argument of inequity also applies to the paying capability of the doctors concerned as the earning capacity of a doctor

varies substantially across specialty, geographical location, and nature of practice. Hence, there is a need to assess and take into account the earning and paying capability of a practitioner before the compensation is awarded.

Discretionary power to award compensation

The Supreme Court in the case of *Nizam Institute of Medical Sciences vs. Prashant S. Dhanaka* awarded less than the amount claimed for physiotherapy, nursing care, and litigation costs without citing reasons for doing the same.^[7] The judge in medical negligence litigation has complete and absolute discretion in awarding compensation, therefore unless evidentiary proof of the expenses incurred, or proposed expenses, is provided, the judge may in his/her own capacity determine the claim to be excessive or not reflective of prevalent costs. The practice of placing complete reliance on a judge may result in ineffective compensation. For example, in *ESI Hospital versus Ram Kishan Yadav* (2012) case the lower court awarded compensation on a humanitarian basis in spite of clearly establishing that there was no negligence from the medical practitioners, thereby sending wrong signals to the community at large. These kinds of humanitarian judgments and awarding compensation may encourage the public at large to approach the court for every negative outcome.

Delay in adjudication of cases

The case of *Balram Prasad vs. Kunal Saha*^[4] saw 15 years of litigation, with varying reasoning across different tribunals, before it finally reached the Supreme Court. Immeasurable delays in court and incessant appeals effectively deny justice to the victims of medical negligence in India. Considering the pace of justice delivery in India, uncertainty regarding their culpability can cause significant mental trauma; furthermore damage to a doctor's reputation is immediate, but acquittal may take a decade or more. For instance, in the *Kunal Saha* case, one of the respondents had died by the time the Supreme Court made a ruling, and a second doctor claimed inability to pay on the grounds of ill health and unemployment.

Doctor or his/her employer (hospital)? Who is responsible for paying compensation?

The contemporary wisdom is that doctors should focus on patient care and the managers with administrative background shall focus on the day-to-day business of a hospital. The hospital as an organization in most cases today is run not by the doctors but by the administrators. These administrators dominate and dictate medical practices in majority of these hospitals. The conflict between quality care (practitioners' responsibility) and financial success (administrator responsibility) has heralded more complexity in the management of the patients. Hospital administrators are largely concerned with generating revenue by imposing deadlines/targets and pressurizing doctors. In such situations, if a case of medical negligence arises, who should be held responsible to pay for the compensation? Is it the doctor, the hospital administrator, or the hospital itself?

In many cases, both doctors and the hospitals have been held responsible for paying compensation.^[8] In a specific instance, the Supreme Court reduced the amount payable by the individual doctors considerably as compared to the

compensatory amount imposed by the National Consumer Forum.^[4] In majority of the situations, an individual doctor may not be in a position to pay the huge compensation (in crores of rupees) until the hospitals are also made party in the litigation. However, an individual private practitioner may not be able to pay the huge amount awarded by the court.

Doctors and their working environment

A doctor in our country generally works in an atmosphere replete with constraints such as poor infrastructure, overcrowding of patients, lack of human resources (both medical and nonmedical), violence against medical personnel, nonavailability of essential drugs and investigations, irregular/erratic supply of medicines, poor quality of supplied medicines, deplorable state of maintenance of medical equipment, administrative work, deadlines and targets to increase the patient turn over, all while receiving inadequate remuneration for their demanding work. In light of the above, it is worth asking whether a medical practitioner can be held liable for medical negligence arising from an inability to diagnose due to the absence of required investigative facilities, poor quality of supplied medicines, or nonmaintenance of equipment and poor infrastructure. Hence, the court should take into account, the exact circumstances the practitioners working and the specific situations that led to the negative outcome so that justice is served.

Defensive practice

The medical professional often has to choose a medical procedure based on various factors such as the clinical condition of the patient, severity of the illness, availability of the medicines/equipment/expertise, time at hand and so forth, and involves some amount of risk management. In the course of treatment, unwarranted outcomes or negative outcomes are known to occur. Often practitioners have to choose risky procedures to save a patient, however, due to the fear of litigation, and the complexity of the numerous laws and rules that regulate the practice of medicine, violence against medical personnel and prevailing norms of awarding exuberant compensation, doctors tend to adopt defensive practice. Practitioners become risk averse not to choose severely ill cases where treatment outcomes may be poor and therefore avoid uncertain procedures that could save patients. Such defensive practice relies more on diagnostic procedures from the standpoint of protecting the doctor from malpractice litigation rather than prioritizing the provision of care and recovery of the patient. All these above factors such as defensive practice, cost toward professional indemnity insurance, numerous laws and rules to comply, hiring an advocate, and loss of time toward litigation will increase the cost of medical practice, which will be transferred to the patients. Having a cap on compensation would discourage malicious lawsuits, prevent the cost escalation of medical care, and also ensures a fear-free atmosphere for practitioners.

Comparative Analysis: Medical Negligence

A basic study of comparative perspectives in dealing with cases of medical negligence shows us that there are many

perils to addressing negligence using punitive compensation as deterrence; and yet, to merely provide compensation in the form of loss of income, and/or hospital costs, does not, in itself address certain growing concerns— that is an increasing occurrence of medical negligence cases,^[25] the dire state of India's health sector,^[26] as well as the need to regulate private actors.

It also puts into perspective, questions that other jurisdictions have been attempting to answer in myriad ways. Yet, to merely transpose arguments for, or against, high compensation in medical negligence claims from any other country, to India, would be incorrect, given the constraints patients and doctors face in the health, as well as the legal sector.^[6]

Tort reform in medical negligence litigation

In the United States of America, increasing medical malpractice litigation and compensation toward victims prompted healthcare lobbyists to demand caps on damages that can be awarded. States in the USA have therefore imposed caps on total damages awarded or on noneconomic damages, or they impose restrictions on damages based on whether a wrongful death occurred, or if the hospital where the victim was treated was a public or private hospital. Table 2 depicts various types of caps on medical negligence across the USA.

The impact of such caps on health-care costs and the practice of defensive medicine have been stated to be minimal.^[27] Arbitrary caps on other hand could cause significant harm to those with limited incomes as punitive damages and noneconomic damages would be curbed, therefore increasing the inequity perpetuated by the medical malpractice litigation.

Several states of the USA have adopted apology and mandatory disclosure legislations to provide victims with alternative remedies. These legislations encourage doctors to admit to their faults and apologize for the same, provided their apologies are not treated as admissions of legal liability in the court. However, the impact of such apology laws has been minimal because of the narrow scope of the definition of apology under the legislations.^[28] Such tort reforms attempt to address the need for transparency within the health sector.

No-fault liability in medical negligence litigation

No-fault liability in medical negligence exists in New Zealand, Denmark, and Sweden. An unconditional, minimum, fixed financial support to the victims of alleged medical negligence resulting in permanent disability or death at the commencement of any trial before any court without any finding(s) or bearing on the ultimate merits of the case. This compensation can be paid either by the defendant/hospital/insurance or by the state

itself.^[29] The basis for no-fault liability is that medical errors are an expected phenomenon that are compensated for through specially instituted tribunals which assess the compensation payable to the victim purely on the presence of a medical error, without having to determine fault - that is actual negligence on the part of a specific party.^[11,30] The no-fault liability system attempts to encourage reporting of medical negligence, and equity in relation to compensation by ensuring all victims get some degree of compensation although it may be substantially lesser.^[31] This acts in the favor of minorities, and the poor who cannot afford to bring their claims to court. However, there is the perception that the absence of fault, disincentivizes safety, and therefore could contribute to more medical errors.^[32]

Alternative dispute resolution in medical negligence litigation

Mediation and arbitration in medical negligence cases have brought to light the different forms of remedies that victims or patients can seek, in addition to compensation, as well as the limited time it takes.^[33] The flexibility of alternative dispute resolution measures allows for the variety of remedies, including (a) admission of negligence on the part of the doctor, (b) institution of training programs to prevent avoidable faults, and (c) emergency training to hospital staff, which by their own admission have provided great satisfaction to the victims.

India: The Fork in the Road

The Indian legal system addresses medical negligence mainly through the consumer courts.^[12] The policy impact of being included under the purview of the Consumer Protection Act, 1987, is that the treatment provided by a doctor which by all definitions, an inexact and variable science with rapid advancement and substantial responsibility, is subject to the same scrutiny as any other service provider, therefore increasing the propensity of the system to solve such matters purely by awarding compensation.

The calculation of compensation is not precise or accurate. It is bound to vary from case to case. This brings in the issue of "subjectivity" of presiding judges. This subjective bias erodes faith in justice system. There is an urgent need to introduce certain broad guidelines, assessment parameters to support the health system in providing quality health care. The compensation awarded needs to be just, reasonable, and prudent.

Table 3 indicates the benefits and disadvantages on applying the reforms discussed to the Indian setting.

Table 2: Caps on various types of compensation awarded

The type of cap on compensation	Meaning	Name of the states
Cap on total damages awarded	Compensation for both economic and noneconomic damages	Louisiana, Colorado, Indiana, Virginia
Cap on noneconomic damages	Compensation toward disability, disfigurement, trauma, or physical pain and mental suffering	Florida, Hawaii, Idaho, Georgia
Restrictions on damages based on whether a wrongful death occurred	Compensation toward any type of fatal accident caused by medical negligence can result in a wrongful death claim	Alaska, Maine, Maryland, Oregon, Wisconsin
Treatment was at public or private hospital	Compensation is based on the treatment was opted at public or private hospital	Colorado

Table 3: Various types of possible solutions, strengths, and weaknesses on applying the reforms to the Indian setting

Possible solutions	Strengths	Weaknesses
Capon damages	There will be a limit on judicial discretion and more certainty regarding the compensation payable	A cap on damages could reduce the incentive to adopt safety measures and could be ineffective in terms of compensating the victim (i.e., restituto in integrum status is not reached)
No-fault liability	Faster and uniform levels of compensation for all medical errors. The compensation mechanism does not depend on the negligent individual but state mechanisms No-fault liability could be adopted in relation to specific medical practice such as vaccine-related injuries (as in the USA)	Institution of a completely new framework: Through health tribunals or an insurance mechanism applicable to all citizens This system is beneficial in countries which provide public health resources effectively but could prove ineffective in India where 80% of the health-care sector is private
Mandatory alternative dispute resolution before initiating civil dispute	Arbitration and mediation provide faster and greater flexibility in dispute resolution and could reduce dependency on protracted litigation	Due to the absence of public records, the incidence of medical negligence cannot be recorded effectively Certification of arbitrators and mediators needs to be instituted to ensure the process cannot be manipulated to benefit either party
Clear guidelines regarding imposition of composition	Guidelines regarding compensation need to be drafted to ensure consumer and civil courts apply the law uniformly; this could provide greater predictability and certainty, reducing the need to appeal judgments of lower courts	There is no certainty that there will be a reduction in appeals in to ensure effective and timely justice for the victims

Conclusion

There is a need to evaluate the manner in which India chooses to address medical negligence. In addition to the fear of defensive medicine, increasing insurance premiums and rise in costs for patients, it is time we are aware of the inequity that the present system perpetuates. Systemic deficiencies such as heavy litigation costs, delayed and protracted litigation, as well as dependence on judicial discretion, do not provide effective justice to victims and could harm doctors and hospitals as well. In a country where there is (a) an abysmal investment in health, (b) the absence of human resources, (c) a huge gap between urban and rural health care, and (d) poor political will to improve the health sector, it would be wise to implement a no-fault liability system within the public health sector and also to have caps on the types compensation after research and discussion. The government needs to act and invest in health care before it is too late. India needs to overhaul the present system of addressing medical negligence using all of the above-mentioned solutions effectively.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

- Jacob Mathew vs. State of Punjab, Supreme Court of India, AIR (2005) SC 3180.
- Suresh Gupta vs. Govt of NCT Delhi, AIR (2004) SC 409.
- Pandit MS, Pandit S. Medical negligence: Criminal prosecution of medical professionals, importance of medical evidence: Some guidelines for medical practitioners. *Indian J Urol* 2009;25:379-83.
- Balram Prasad vs. Kunal Saha, (2014) 1 SCC 384.
- Baru RV. Challenges for regulating the private health services in India for achieving universal health care. *Indian J Public Health* 2013;57:208-11.
- Saha K, Shetty D. Are large compensation payouts for negligence good for medicine in India? *BMJ* 2014;349:g5229.
- Nizam's Institute of Medical Sciences vs. Prashant S. Dhanaka, (2009) 6 SCC 1.
- Krishnakumar V, vs. State of Tamil Nadu, AIR (2015) SC 4283.
- Sekhar MS, Vyas N. Defensive medicine: A bane to healthcare. *Ann Med Health Sci Res* 2013;3:295-6.
- Paschim Bhangra Khet Mazdoor Samiti vs. State of West Bengal AIR (1996) SC 2426.
- Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994;343:1609-13.
- Joga Rao SV. Medical negligence liability under the consumer protection act: A review of judicial perspective. *Indian J Urol* 2009;25:361-71.
- Mamdani B. Medical malpractice. *Indian J Med Ethics* 2004;12:57-8.
- Malay Kumar Ganguly vs. Sukumar Mukherjee and Ors., (2009) 9 SCC 221.
- Agarwal AK. Medical Negligence and Compensation in India: How Much is Just and Effective? W.P. No. 2014-03-27; 2014. Available from: <http://www.iimahd.ernet.in/assets/snippets/workingpaperpdf/15451890132014-03-27.pdf>. [Last accessed on 2016 May 29].
- Rajesh and Ors. Rajvir Singh V and Ors., (2013) 9 SCC 54.
- Kusum Sharma and Ors. vs. Batra Hospital and Medical Research Centre and Ors., AIR (2010) SC 2052.
- Sarla Verma vs. Delhi Transport Corporation (2009) 6 SCC 121.
- Oriental Insurance Company Ltd. V. Jashuben and Ors., (2008) 4 SCC 162.
- Arun Kumar Agarwal vs. National Insurance Company AIR (2010) SC 3426.
- Reshma Kumari vs. Madan Mohan and Ors., (2009) 13 SCC 422.
- Indu Sharma vs. Indraprasta Apollo Hospital and Ors., (2015) 2 CLT 454 (NC).
- Medical Council of India. Professional conduct, Etiquette and Ethics Regulations; 2002. Available from: <http://www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulations2002.aspx>. [Last accessed on 2016 Jul 29].
- Landes WM, Posner RA. The Economic Structure of Tort Law. Cambridge, MA: Harvard University Press; 1987.
- Jha AK, Larizgoitia I, Audera-Lopez C, Prasopa-Plaizier N, Waters H, Bates DW. The global burden of unsafe medical care: Analytic modelling of observational studies. *BMJ Qual Saf*

- 2013;22:809-15.
26. Das J, Holla A, Das V, Mohanan M, Tabak D, Chan B. In urban and rural India, a standardized patient study showed low levels of provider training and huge quality gaps. *Health Aff (Millwood)* 2012;31:2774-84.
27. Paik M, Black BS, Hyman DA, Silver C. Will tort reform bend the cost curve? Evidence from Texas. *J Empir Leg Stud* 2012;9:173-216.
28. Mastroianni AC, Mello MM, Sommer S, Hardy M, Gallagher TH. The flaws in state "apology" and "disclosure" laws dilute their intended impact on malpractice suits. *Health Aff (Millwood)* 2010;29:1611-9.
29. Pandya SK. Compensation by state: Eliminating legislation against doctors. *Issues Med Ethics* 1993;1:4.
30. Gaine WJ. No-fault compensation system. Experience elsewhere suggests it is time for the UK to introduce a pilot scheme. *Br Med J* 2003;326:2.
31. Mello MM, Kachalia A, Studdert DM. Administrative compensation for medical injuries: Lessons from three foreign systems. *Issue Brief (Commonw Fund)* 2011;14:1-18.
32. Bovbjerg RR, Sloan FA. No-fault for medical injury: Theory and evidence. *Univ Cincinnati Law Rev* 1998;67:53.
33. Sohn DH, Bal BS. Medical malpractice reform: The role of alternative dispute resolution. *Clin Orthop Relat Res* 2012;470:1370-8.